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# Implementing a Discharge Tool to Decrease the Length of Stay in the Observation Unit

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## Background

Observation units provide care to patients coming from the Emergency department. An Observation unit uses the appropriated monitoring, diagnostic testing, therapy, symptom assessment and laboratory tests for the purpose of determining whether a patient will require further treatment as inpatient or can be discharged safely home. Emergency department crowding represents a crisis that may affect the quality and access of health care. (Tygesen, 2016).

Patients cared for in dedicated observation units are diagnosed and discharged home faster than observation patients in the inpatient setting. They avoid costly admission charges and the scarce inpatient bed capacity is more appropriately utilized (Kowalaski, 2018).

Providence St. Vincent's Medical Center (PSVMC) is a 523 bed, tertiary care, Magnet designated hospital. Through expert opinion among staff members in the Clinical Decision Unit (CDU), a 20 bed observation unit, several barriers for early discharge were identified. These top barriers were transportation, example family members taking a long time to pick up patients, delivery of medications from pharmacy, prescriptions pick up, test and laboratory results as well as physician consults.

An integrated review of the literature on challenges confronting discharge, saw that a discharge checklist likely will improve the discharge process (Nosbusch, 2010).

Implementing a discharge checklist tool in the observation unit has a potential to help organize care and facilitate quicker follow up on outstanding test results or necessary actions hindering discharge.

## Purpose

The purpose of this study is to decrease the length of stay and increase the capacity to serve more patients from the Emergency department.

The discharge tool's purpose is to enhance communication with nursing and care coordination teams, triggering earlier discharge planning.

### Discharge Tool

Patient	Discharge Order	Test Results	Physical / Occupational Therapy	Medications	MD Consults	Care Management	Transportation
Patient 1							
Patient 2							
Patient 3							

## Methods

This is a prospective interventional IRB approved study of discharged observation patients. Observation status patients discharged home were included in the study; patients discharged to skilled nursing facility, transfer to inpatients, critical care and surgery were excluded.

Literature and unit staff expert opinions were used to identify key factors that impact length of stay that were developed into a discharge tool that includes discharge orders, test results, physical and occupational therapy consults, medications, doctor consults, care management follow up and transportation.

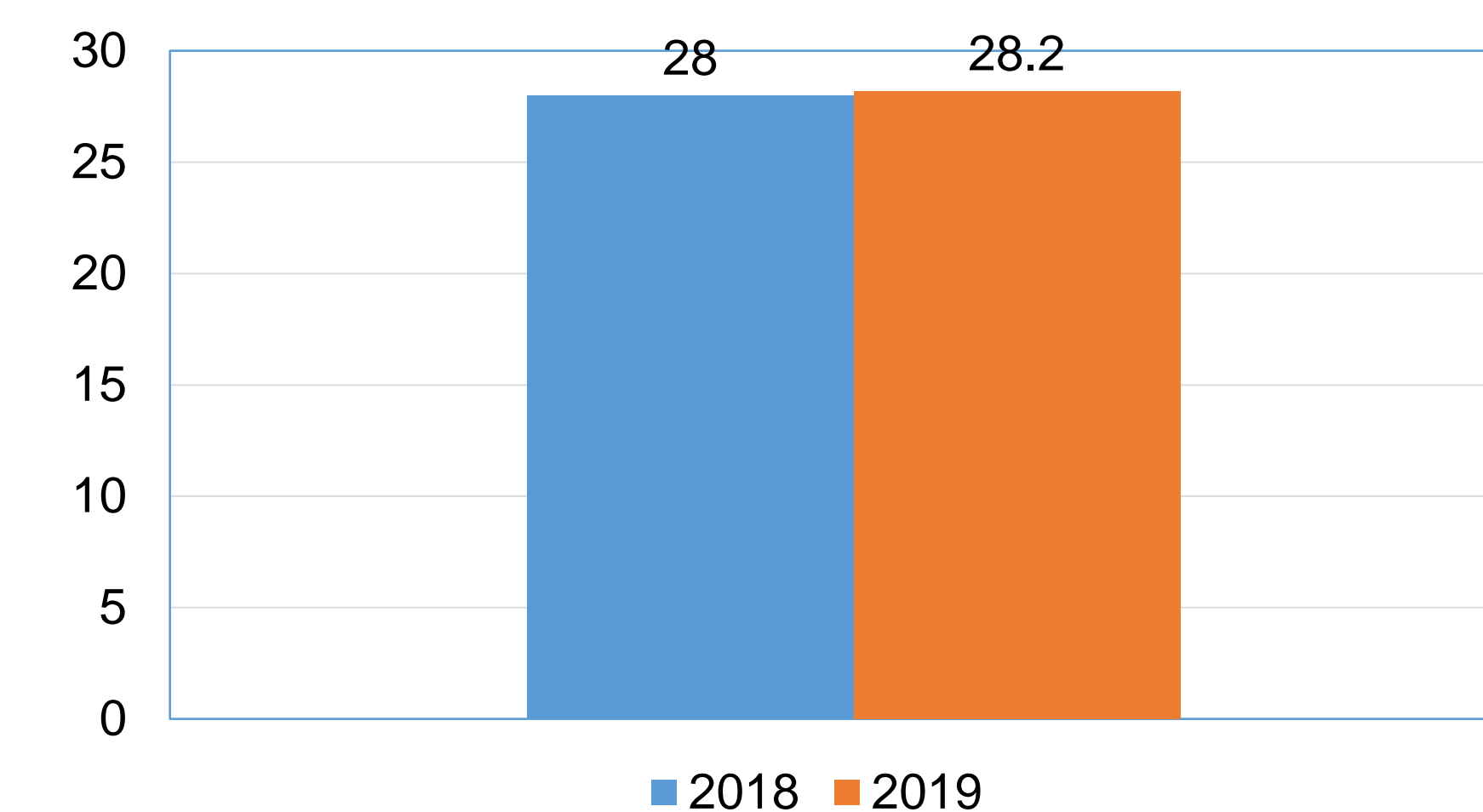
The discharge tool was applied to a white board at the nurse's station where staff then updated the checklist. Check marks were placed in corresponding boxes to signify that certain tasks had been performed. When all necessary tasks had been completed, the patient was ready for discharge. This discharge tool was implemented on March 1, 2019. Training, education and communication concerning the tool was conducted with the team members.

This study compared the length of stay pre and post implementation of a discharge tool. Length of stay was determined from electronic medical records (Epic) for patients who were discharged home in March – May 2018 and March – May 2019.

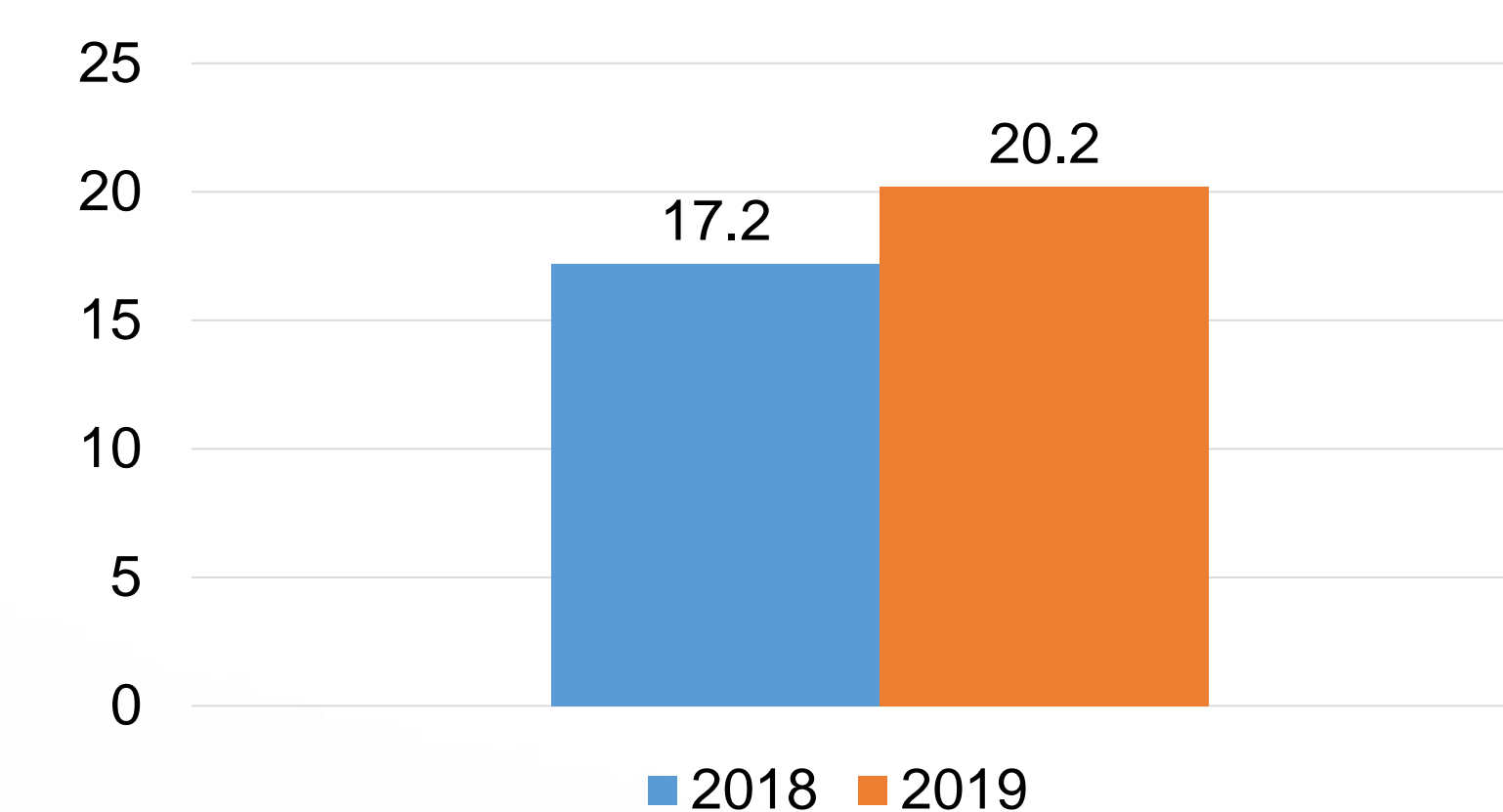
Source data was collected by running reports from the Epic charting system and comparing the average length of stay from 2018 to 2019 after the discharge tool had been implemented.

Unrelated to the discharge tool, the number of beds in the Clinical Decision Unit decreased from 26 beds in 2018 to 20 beds in 2019.

Average Length of Stay (in hours) of Observation Patients



Total Number of Patients Served per Bed per Month



## Results

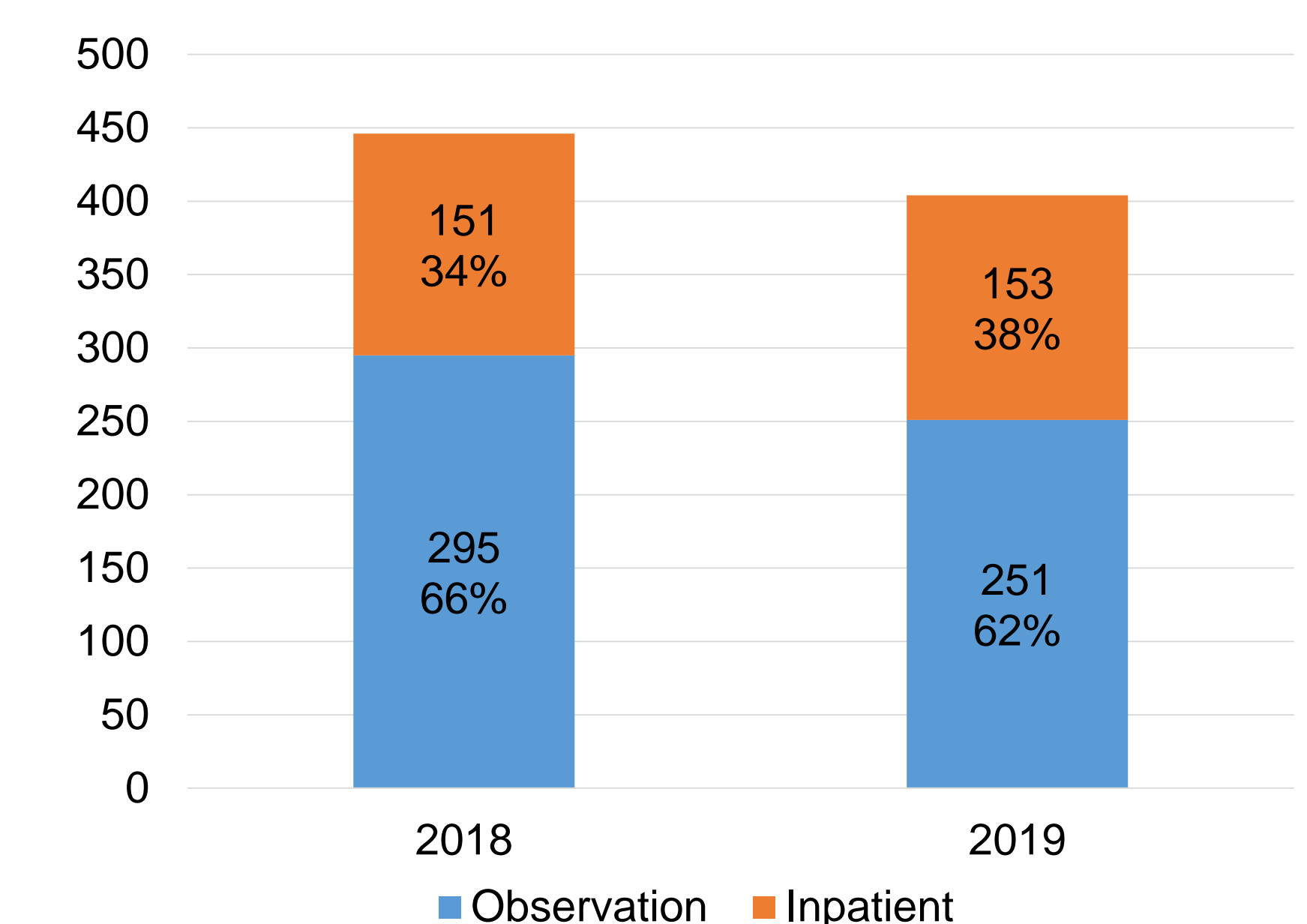
The average length of stay for observation patients discharged home remained similar: an average of  $28.0 \pm 1.7$  in March-May 2018 and  $28.2 \pm 1.4$  hours in March-May 2019.

The total number of patients served per bed did increase. A total of 1,339 patients discharged from CDU March-May 2018 when CDU had 26 beds, and 1, 212 patients were discharged from CDU's 20 beds March – May 2019, thus 17.2 patients were served per bed each month before implementing the discharge tool, and 20.2 patients per bed per month were served after the tool was implemented.

## References

- 1.Kowalaski, C.(2008).Making the Case for Dedicated Observation Units. Retrieved from <https://www.besler.com/dedicated-observation-units/>
- 2.Nosbusch,J.M.,Weiss, M.E., Bobay,K.L.(2010). An Integrated review of the literature on challenges confronting the acute care staff nurse in discharge planning. Journal of Clinical Nursing, 20,754-774.doi:10.1111/j.1365-2702.2010.03257.x
- 3.Tygesen,G.B., Hakonawn, S.J.,Uhrenfeld,L. (2016). Effectiveness of decision tools used to identify adult patients suitable for early discharge from emergency departments. JBI Database of Systemic Reviews & Implementation Reports 2016;14(1)67-76.doi:10.11124/jbisir-2016-1801

Patient Status (Observation and Inpatient) by Year



## Discussion/Conclusions

Length of stay did not change related to the discharge tool. It is possible that the discharge tool was not fully utilized. The use of the discharge tool was not thoroughly audited. Daily use cannot be verified, although the last task performed prior to discharge for a portion of the discharged patients was documented to determine consistent barriers to discharge. Anecdotally, use of the tool helped create awareness of necessary medical consults, physical and occupational therapy, and pointed towards transportation as most commonly being the last task to be performed.

Other changes occurred in the clinical decision unit at the same time including a change in manager, newly hired Nurse Practitioners and higher hospital occupancy in 2019. The percentage of inpatients on the unit increased from 34% to 38%, requiring more attention to be focused on to these patients and may have decreased the efficiency of the discharge process. Accordingly, it is possible that these factors increased the length of stay while the discharge tool decreased it, resulting in the same length of stay.

Anecdotally it may be necessary to track only consults, physical and occupational therapy and transportation as they appeared to have the greatest impact on discharge.

The recommended next steps are to simplify the tool, audit its use, work with new leadership to ensure participation, and evaluate whether the tool will result in decreases clinical decision unit length of stay.

